

Completion Instructions for ADP 1592

(Revised 8/97)

THIS FORM SHOULD BE USED FOR BOTH THE COUNTY AND THE DIRECT CONTRACT PROVIDERS

I. GENERAL

The ADP 1592 - MONTHLY CLAIM FOR DRUG/MEDI-CAL REIMBURSEMENT AND MONTHLY PROVIDER SERVICE AND REVENUE SUMMARY is used for reporting total Drug/Medi-Cal units of service, total dollar amount claimed, total revenue collected/reported by source, claim adjustments and the net claim amount by provider.

II. HEADING INSTRUCTIONS

- a. Type of Submission - check the type of claim being submitted
- b. Check the type of claim being submitted either by the County or the Direct Contract Provider.
- c. County - enter name of county submitting claim
- d. County Code - enter the two digit county code
- e. Contract # - enter the Direct Contract Provider Number (for DIRECT CONTRACT PROVIDERS ONLY)
- f. Claim for Mo/Yr - enter month/year in which the claim is being submitted.
- g. Program Code - check the appropriate box for Drug Services (20) or Perinatal Services (25)
- h. Fiscal Year - enter fiscal year of service
- i. Date - enter the date this form was completed
- j. Page/of - enter each page number and total of pages (i.e., page 1 of 9)

III. COLUMNAR INSTRUCTIONS

- a. Provider Name - enter name of program providing services. If Direct Contract Provider - enter the provider name.
- b. Provider Number - enter the four digit provider number assigned by the Department of Alcohol and Drug Programs
- c. Service Function Code (SFC) - enter the two digit SFC; 20-22= Methadone Dose, 23-25 = LAAM Dose, 26-27=NTP Individual Counseling, 28-29=NTP Group Counseling, 30-39=Daycare Habilitative, 40-49=Perinatal Residential, 50-59=Naltrexone, 80-84=Outpatient Drug Free Individual Counseling, 85-89=Outpatient Drug Free Group Counseling.
- d. Units of Service - for each service function code, determine and enter the units of service rendered or reported by each provider for the claim month
- e. Amount Claimed - for each service function code, determine the total dollars, including cents, incurred or reported by the provider for the claim month.

NOTE!! ALL INCURRED OR REPORTED DOLLARS BILLED MUST BE SUPPORTED BY THE ADP 1584 DRUG/MEDI-CAL ELIGIBILITY WORKSHEETS

- f. Adjustments to the Gross Claim: REVENUE - for each service function code and each provider, determine and enter the total revenue collected or reported during the claim month by revenue source. REVENUE SOURCES NOT LISTED ON FRONT MAY BE REPORTED UNDER THE "OTHER" COLUMN AND \$ AMOUNT ENTERED. The revenue not listed on front is: Grants, Adjustments - enter adjustments by provider (only deduct current FY adjustments).

- g. Total Revenue Adjustments - enter total of both revenue and adjustments (should never show a negative \$ amount).
 - h. Net Claim - net claim equals amount claimed, minus total revenue and/or adjustments.
 - i. Page Totals - enter column totals for units of service, amount claimed, total revenue and/or adjustments and net claim.
 - j. Grand Totals - on the last page of the monthly invoice, enter the grand totals of amount claimed, total revenue and/or adjustments and net claim.
- IV. County Fiscal Representative or Direct Contact Provider Representative - the signature and phone number (including the area code) of the responsible county/contractor representative for contact purposes.
- V. CERTIFICATION STATEMENTS - sign the appropriate certification statement.
- a. COUNTY CERTIFICATION - the signature of the County Alcohol/Drug Program Administrator (FOR COUNTY ONLY)
 - b. DIRECT CONTRACT PROVIDER - the signature of the Contract Administrator (FOR DIRECT CONTRACT PROVIDERS ONLY).
- VI. FISCAL OFFICER - signature of the County Auditor Controller or Finance Officer, or the Direct Contractor Finance Officer (FOR BOTH COUNTY AND DIRECT CONTRACT PROVIDERS).
- NOTE: THREE ORIGINAL SIGNATURES ARE REQUIRED ON THE ADP 1592. SIGNATURES ARE REQUIRED ON ANY PAGE ON WHICH A GRAND TOTAL IS ENTERED.
- VII. SUBMISSION INSTRUCTIONS:
- 1. The original Eligibility Worksheet (ADP 1584).
 - 2. Original Adjustments by Provider form (ADP 5035 Rev.) with original signatures, and two copies (if adjustments are made to this month's claim).
 - 3. Original Monthly Claim for Drug/Medi-Cal Reimbursement (ADP 1592) with original signatures and three (3) copies.

MAIL TO:
Department of Alcohol and Drug Programs
Drug/Medi-Cal Section
1700 "K" Street
Sacramento, CA 95814-4037

ADP 1592

CLAIM SUBMITTAL FORM